DATE TO BEGIN: ____________________ CYCLE: ____________________

REGIMEN/PROTOCOL: HIGH DOSE CYTARABINE (HiDAC)

PRIMARY DIAGNOSIS: □ Acute Myelogenous Leukemia (AML) Consolidation □ Other*: ____________________

*When selecting other diagnosis please provide protocol

ALLERGIES/REACTIONS:

Goal of Chemotherapy: □ Curative □ Palliative □ Neoadjuvant □ Adjuvant

MD to indicate which weight to use: □ Actual □ Ideal □ Adjusted

HEIGHT (cm): ACTUAL WEIGHT (kg): IDEAL WEIGHT (kg): ADJUSTED WEIGHT (kg):
and BSA (m²): and BSA (m²): and BSA (m²):

Dosing calculations to be completed by Pharmacist:

<table>
<thead>
<tr>
<th>CHEMOTHERAPY MEDICATION ORDERS</th>
<th>DOSE (mg/m²)</th>
<th>BSA (m²)</th>
<th>DOSE TO BE GIVEN</th>
<th>ROUTE</th>
<th>INFUSE OVER</th>
<th>DATE(S) AND FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cytarabine</td>
<td>3 g/m²</td>
<td>X</td>
<td></td>
<td>IV</td>
<td>3 hours</td>
<td>Every 12 hours on Days 1, 3 and 5</td>
</tr>
</tbody>
</table>

HYDRATION ORDERS

Pre-chemo hydration optional if hydrated 1.5-2 Liters before or low risk of tumor lysis syndrome

<table>
<thead>
<tr>
<th>HYDRATION SOLUTION</th>
<th>ADDITIVES</th>
<th>RATE</th>
<th>DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BEFORE CHEMOTHERAPY

DURING CHEMOTHERAPY

AFTER CHEMOTHERAPY

HOLD CHEMOTHERAPY FOR THE FOLLOWING REASONS:

Absolute Neutrophil Count (ANC) Less Than ____________________ (typically less than 1,000)

Platelets Less Than ____________________ (typically less than 100,000)

Other: ____________________

Physician Initial: ____________________

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Franciscan Health System
St. Joseph Medical Center, Tacoma, WA
St. Francis Hospital, Federal Way, WA
St. Clare Hospital, Lakewood, WA
St. Elizabeth Hospital, Enumclaw, WA
St. Anthony Hospital, Gig Harbor, WA

PHYSICIAN ORDERS

CHEMOTHERAPY:
HIGH-DOSE CYTARABINE (HiDAC)
**PHARMACY TO MANAGE ANTIEMETICS**

<table>
<thead>
<tr>
<th>ANTIEMETIC ORDERS/DRUG NAME</th>
<th>DOSE</th>
<th>ROUTE</th>
<th>TIMING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ondansetron</td>
<td>☐ 16 mg</td>
<td>PO</td>
<td>30 minutes pre-Cytarabine (Days 1, 3, 5)</td>
</tr>
<tr>
<td>☐ 24 mg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Dexamethasone</td>
<td>8 mg</td>
<td>PO</td>
<td>30 minutes pre-Cytarabine (Days 1, 3, 5) THEN daily (Days 6-7)</td>
</tr>
<tr>
<td>☐ Fosaprepitant + Dexamethasone (optional)</td>
<td>150 mg</td>
<td>IV</td>
<td>30 minutes pre-chemo (Day 1)</td>
</tr>
<tr>
<td></td>
<td>12 mg</td>
<td>PO</td>
<td>THEN 30 minutes pre-first dose Cytarabine (Day 1)</td>
</tr>
<tr>
<td></td>
<td>8 mg</td>
<td></td>
<td>Daily (Days 2-7)</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>0.5-1 mg</td>
<td>PO</td>
<td>30 minutes pre-chemo times 1 dose PRN anxiety</td>
</tr>
</tbody>
</table>

**PRN ANTIEMETICS (FOR INPATIENT USE)**

NOTE: Number the antiemetics below in the order to be used. The nurse will select #1 as the first medication to be given and may alternate #2. If orders chosen are not numbered, the nurse will contact the prescriber for clarification.

<table>
<thead>
<tr>
<th>Antiemetic</th>
<th>Dose</th>
<th>Route</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorazepam</td>
<td>0.5-1 mg</td>
<td>IV</td>
<td>Every 4 hours PRN nausea/vomiting/anxiety</td>
</tr>
<tr>
<td>Promethazine</td>
<td>12.5-25 mg or 6.25-12.5 mg**</td>
<td>IV</td>
<td>Every 4 hours PRN nausea/vomiting</td>
</tr>
</tbody>
</table>

**Outpatient Prescription(s):** (for outpatients or early discharge)

**For patient 65 years old and greater**

**TESTS:**
☐ MUGA Scan
☐ ECG
Other: ________

**LABS – NOW:** ☐ CBC ☐ BMP ☐ CMP ☐ Other ________

**LABS – DAILY:** ☐ CBC ☐ BMP ☐ CMP ☐ Other ________

☐ Urine Output: If urine output is less than ___________ times ___________ days

☐ Nurse May Initiate CVAD Management Per Nursing Protocol #910.00
☐ Nurse May Utilize Local Anesthetic For CVAD Access Per Nursing Protocol #788
☐ Nurse May Initiate IV Catheter Care, Outpatient Physician Order #858
☐ For Infusion Reactions Initiate Drug Related Hypersensitivity Physician Order #774

**MEDICATIONS:**
☐ Dexamethasone 0.1% eye drops – 2 drops in each eye four times daily; start prior to cytarabine and stop 24 hours after last dose of cytarabine
☐ Allopurinol 300 mg PO daily
Other: ________

**NOTE:** These orders should be reviewed by the attending physician, appropriately modified for the individual patient, dated and signed below.

DATE | TIME | PHARMACIST’S SIGNATURE
--- | --- | ---
| | | |

DATE | TIME | PHYSICIAN’S SIGNATURE
--- | --- | ---
| | | |

Another brand of drug, identical in form and content, may be dispensed unless checked. ☐